The Easiest—

Affordable High-quality Health Care for All Is the Easiest Problem to Fix in the United States

Not easy, just easier than any of the others—because we already spend enough

And also the most strategic because unless we fix health care, we won't be able to find the money to address the others

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U.S. health care is heavily addicted to more money each year to pay for business-as-usual.
When something can't continue, it stops.
In a few years—maybe 3 or 5 or 10—flows of added money will dry up.

How will U.S. health care respond?
It now has no plan to cope with the crisis resulting from tighter revenue.
Patients may be unable to needed obtain care, while needed caregivers may go broke.

When U.S. health care falls into crisis, political pressure for reform will be irresistible.
But pressure for reform will be pointless if we don't prepare now to act effectively.
"Never let a good crisis go to waste."
Just as nations prepare for natural disasters, we must prepare to reform U.S. health care.

Overcoming this crisis will be impossible unless we prepare and test a range of reforms.
Reforms must seek ways to use today's vast—and already adequate—sums to fully protect and serve all Americans and sustain all needed caregivers in the right places.

That will require squeezing out most of the clinical and administrative waste, the high prices, and the theft that snare up to 50 cents of each health dollar. And turning that fat into clinical bone and muscle. Only a crisis will impel us to try to do this. But it's a tough, complicated job.

Reforming U.S. health care requires safely containing costs, solidly covering all people, organizing and paying caregivers in trustworthy ways, ensuring solid primary care for each American, sustaining the right hospitals and other caregivers where they are needed, and addressing long-term care, mental health, pharma, and quality and appropriateness of care.

Our nation can win affordable and high-quality health care for all.
That will build confidence and liberate money to address harder problems our nation faces.

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This work is dedicated to Sandy, Josh, and Matt; and to the memory of Ruth and George, Ethel and Alfred, Rose and Herman, and Sylvia and Harry.

Contents

Paradoxical but powerful

Today, health reformers merely tinker because they consider serious change to be politically and financially impossible. But business-as-usual is unsustainable and a deep health care crisis is possible. That will mean an opportunity for real reform. We should prepare for that opportunity.

Cost must be contained if all Americans are to be covered financially. **But to contain cost safely—without harming vulnerable people—we must cover everyone**. Today, small incremental reform looks like the only politically possible path. But access, cost, caregiver configuration, and quality are so interwoven that they need to be pursued in a coordinated way.

We should prevent illness or injury whenever possible. But prevention inevitably fails. That's when medical care becomes valuable. But it also has a 100 percent failure rate.

Social and behavioral forces influence our health more than does medical care. But spending lots more on social determinants will be impossible until health care costs are capped.

Besides, talk of spending more on social determinants of life won't cut health spending or improve coverage. It does let health care off the hook. Fixing health care shouldn't be evaded.

So what do we hope to accomplish by spending almost one-fifth of the economy on health care? I suggest "medical security"—confidence that each of us will get effective, quick, competent, and kind care when ill or injured—without worry about the bill.

Health spending suffices to finance medical security for all. But because ½ of the health dollar is wasted, many of us are insecure. Reform requires cutting waste, and that requires **paying doctors, hospital, and other caregivers in financially neutral ways—**ways that liberate them from worry about their own financial well-being. And strengthening their professionalism—so we can trust them spend our vast but finite health dollars to do as much good as possible.

It is time to abandon the sterile debate between competitive free markets or detailed government regulation as remedies. No such markets do or can exist in health care. Market rhetoric is naïve, ideological or a calculated smokescreen for financial pillaging and plundering.

Governments must make big, vital decisions about full coverage, cost containment, caregiver configuration, and quality. They should not be asked to regulate details, a job they can't do well.

The care we get depends heavily on the caregivers we've got. Yet no one is accountable for the configuration of caregivers—how many, what kinds, and in what locations—primary caregivers, hospitals and ERs, nurses, dentists, social workers, and all others. Good primary care is essential to protecting access and quality while containing cost.

Sadly, neither financially incentivizing (bribing) nor punishing caregivers can protect access, contain cost, or improve appropriateness or quality of care. They can all be gamed by caregivers—and some can be gamed by payers. Their main effect is to corrode doctors' professional ethics and hospitals' fiduciary duties. And citizens' trust in health care.

Doctors' decisions about how to diagnose and treat individual patients control spending of almost 90 percent of health care dollars are spent. If doctors want to regain clinical independence and autonomy—liberation from prior approval, claims denials, bosses' rules and productivity standards, and death by a thousand paper cuts, they must embrace responsibility for spending finite—but vast—dollars carefully and in light of evidence about what care works.

Main points

1. Affordable medical security for all is the easiest problem to fix in the United States. Until we do fix it, we will be condemned as incompetent, cruel, lazy, and venal. When we do fix it, we will win a victory for competence and compassion, one that liberates hundreds of billions of dollars yearly. Victory will both inspire and enable us to tackle harder problems—like affordable housing, education and job training, national and neighborhood and personal security, safe energy, and the rest of the things you care about. **Health care, itself, is strategic**.

2. It's easiest, first, because we already spend enough. And, second because ½ of health spending is wasted. That's why we fail to cover everyone, give much less care than the rich democracy average, at double the rich democracy average cost per citizen, and die younger. It's easiest, third, because fixing it doesn't require comprehensive social/economic reform.

3. Anarchy plagues U.S. health care. It stems from failure of both a competitive free market and competent government regulation. Competition is the opiate of the managers—and of most health economists. Politicians' have wasted time cleaning up the debris left by market failure. They should instead have been making the tough strategic decisions about covering all Americans, containing cost, and securing the right caregivers in the right places.

4. Our caregivers are financially addicted to higher doses of money each year. Payers flail to cut cost by suppressing access—by boosting out-of-pocket payments, denying care, incentives to under-serve, and administrative death by 1,000 paper cuts. Motivation to contain cost remains weak partly because no one expects to benefit from it. Waste is hard to blast loose.

5. At some time—3, 5, or 10 years hence—added revenue will cease to flow.

6. **This will happen at a time of crisis** caused by some combination of economic stresses of inflation or recession; political stresses of federal interest payments, deficits, debts, and divisiveness; clashes over social stresses; and defense spending stresses stemming from behavior by Russia, China, Iran, or others.

7. People will disagree about the chance of a crisis but the harm would be enormous if one arose. Preparation now provides insurance that we'll be able to cope with crisis later. That entails developing plans to protect patients and caregivers—plans for squeezing out waste and using the savings to pay for care. Reform means putting our money in the hands of doctors and others under arrangements that allow us to trust them to care for all of us well and affordably.

8. Winning health security requires fixing health care first. Social determinants of life affect health very powerfully. But finding the money and the political will to seriously address them won't materialize until we cut health costs and assure all Americans health security.

9. **It takes a crisis** to spur action and it takes preparation to craft action that will be effective.

10. Fixing health care entails completely covering all people financially, assuring needed caregivers the finite revenue that is adequate to finance efficient and equitable delivery of needed care, reconfiguring caregivers so we have the right types and numbers in the right places, and paying caregivers in financially neutral ways that allow us to trust them to marshal our inevitably finite resources to do as much good as possible—as equitably as possible. **Each is essential. Even better, each of these reforms supports all of the others**

Overview

Health security's four elements are full financial coverage for all people, cost control, the right caregivers in the right places, and equitable delivery of appropriate and high-quality care.

U.S. health care has long been the most costly, unequal, and ineffective across the world's rich democracies.

Winning health security requires reforming health care and cutting waste.

Winning health security requires addressing a number of elements inside health care in a coordinated way. These include financially covering all people, containing costs, reforming methods of paying doctors and hospitals that puts dollars in the hands of caregivers who are willing and able to spend them to do as much clinical good as possible, configuring caregiving to match patients' needs, and leveling up the appropriateness and quality of care.

Prevention is valuable in itself but is no substitute for reforming health care. Prevention has a 100 percent failure rate. Medical care is actually useful when we are inevitably ill or injured.

Addressing social determinants of life (SDLs) like housing, nutrition, education and job training, the environment, community and personal security, and personal behaviors would improve health and all other aspects of life.

But that would not cut health costs. Besides, big money to finance investments in SDLs is lacking. One reason is that rising health care costs sponge up rising shares of GDP.

Strategic health care reforms cut waste to finance health security for all, protect needed caregivers, and liberate dollars to address other domestic and international demands.

U.S. health care's sustainability has long been plagued by rising costs, growing administrative and clinical waste, and inattention to primary care, needed hospital services, long-term care, and mental health. Powerful groups of doctors, hospitals, other caregivers, insurance companies, and investors have fought for ever more money to finance business-as-usual.

All have resisted reform despite growing suppression of needed care, rising administrative waste and mistrust and theft, soaring costs, and provision of much care of marginal clinical value. These are all manifestations of growing anarchy in U.S. health care.

The nation's current prosperity is fragile, bought in part by high federal deficits that are unprecedented in good economic times.

Those in Washington who seek to shrink deficits and to find money to address other pressing domestic and international challenges will push Congress to freeze spending on Medicare, Medicaid, and ACA subsidies. The freeze will frighten caregivers, employers, state and local governments, and citizen-patients. All will come to agree that there's no alternative to squeezing out wasted health care spending and using it to finance both health security for all people and financial stabilization of all needed caregivers. By 2035, putting health care on a sound foundation will remind Americans we can be both competent and compassionate, building confidence in tackling the hard jobs before us.

Part I – Chapters 1-5

Chapter 1, purportedly written in 2035, describes why and how the U.S. chose to cover all people, cap spending and costs, and paid caregivers in ways commensurate with affordable care for all. Some big problems were fixed and foundations were laid for fixing others.

Returning to 2025, chapter 2 offers evidence and argument that affordable and high-quality medical security for all is the easiest problem to fix. Improving prevention and public health and addressing social determinants of life complement—but do not substitute for—medical care. Prevention has a failure rate of exactly 100 percent. And it does not cut health care spending.

As discussed in chapters 5, 7, 8, 9, 11, and 12, indirect attacks on health care cost, access, caregiver configuration, and quality problems have very rarely succeeded. Often, they were not intended to succeed—but rather to posture to placate aggrieved, noisy, but politically weak people.

Finding hundreds of billions of dollars to finance wholesale action on social determinants is a fantasy—for now. And worse, that fantasy lets health care itself off the hook. It reduces pressure to fix health care. Fixing health care will liberate vast sums to address social determinants.

Chapter 3 offers complementary evidence that we spend enough on health care. It asserts that clinical waste, administrative waste, excess prices, and theft consume up to one-half of U.S. health spending. And that squeezing out waste requires coordinating four things: protecting all people financially, containing cost, paying caregivers in financially neutral ways that are commensurate with coverage and cost control, and better configuring doctors, hospitals, and other caregivers in proportion to citizens' need for health care.

Chapter 4 argues that financial and clinical anarchy beset U.S. health care owing to failures of competitive free markets and of competent government action. None of the 7 requirements for such markets are met in health care—or can be. Advocating markets has the effect of justifying incentives, greed, and profits—not one of which is legitimate or functional in health care.

Chapter 5 describes how market failures evoke regulatory responses. It explains why these are rarely competent or effective. U.S. governments generally ignore making the big, strategic health care decisions well—decisions about coverage, cost control, caregiver payments, and configuration, or quality of care. Failure to make the big decisions well, combined with the many abuses that stem from dysfunctional markets, obliges government to try to craft complicated—and generally unworkable and unenforceable regulations. Public regulatory activity in health care mostly amounts to a game of whac-a-mole that the moles and their lawyers regularly win—and that undermines confidence in public action.

The alternatives to relying on failed markets and failed regulatory micromanagement are first, to ask government to make a modest number of big decisions well and second, to find ways to put money in the hands of doctors, hospitals, and other important caregivers under conditions that allow us to trust them to spend it as effectively, efficiently, and equitably as possible.

Transition – Chapter 6 sums up the difficulties plaguing U.S. health care and pivots toward eight specific areas for reform. Together, the eight areas entail coverage for all people, caps on spending and costs of care, paying trustworthy caregivers in trustworthy ways, securing the right

numbers and types of caregivers in the right places, streamlining organization and delivery of care, and improving appropriateness and quality. It summarizes what needs to be done and also what needs to cease.

Crafting tools to monitor implementation of the complementary reforms will be challenging. Which measures of progress are important, easy to obtain and gauge accurately, and hard to manipulate to enrich special interests or weaponize arguments against reform?

Part II – Chapters 7-17

Each chapter in this section describes an important problem, analyzes is causes, identifies possible remedies, and suggests which remedies are more likely to work, to be acceptable politically and popularly, and to mesh well with remedies to other problems.

Chapter 7 identifies cost, political, and other barriers to assuring financial coverage for all Americans' health care costs. It points to the growing reliance on care suppression to save money and catalogs the methods of care suppression. It assesses the range of policies to overcome those barriers. It explains why solid coverage for all people is essential to controlling costs for all of us.

Key reform elements include cutting out-of-pocket burdens substantially, shifting all payers steadily toward paying the same prices for the same care, primary caregivers for all Americans, ending narrow networks of caregivers, and effective cost controls that obviate reliance on care suppression in hopes of saving money.

Chapter 8 analyzes reasons for decades of failure to contain cost and suggests practical steps forward. Two of the causes were weak motivation to contain cost because no one stood to gain much and many stood to lose, and the belief that high waste and high cost were deeply embedding in health care. Effective cost control becomes possible after realizing that it is essential to cope with the freeze in federal health dollars, that covering everyone was essential to containing cost, and that attacking waste could liberate very large sums to protect access and sustain needed caregivers.

Chapter 9 examines the mechanics and politics of paying doctors, hospitals, and other caregivers in ways that are compatible with medical security for all, cost control, reconfiguring caregivers, and more appropriate and higher-quality care. If payers make $XXX available to care for a defined group of people, how does that translate into fair and acceptable payment for individual doctors, hospitals, nursing homes, dentists, and others? Since neither competitive free markets nor competent government regulation of details can function effectively in health care, self-regulation by caregivers is the only remaining option. Caregivers must be paid in ways that make them financially neutral in their clinical decisions, and that liberate them to carefully marshal huge but finite dollars to do as much good as clinically possible.

Chapter 10 takes up ways to organize and deliver care more effectively, efficiently, and equitably. Since for-profit caregiving can't be legitimate—because no competitive free market is present, since non-profits have often themselves been untrustworthy, and since no method of organizing and delivering care regulates itself—the motivation and competence of institutional trustees and CEOs are vital to shaping accessible, affordable, equitable, and effective care. How to get the right people?

How can coverage, caregiver configuration, and appropriate, high-quality care for all fit together? How can doctors, nurses, other clinicians, hospitals, nursing homes, home health care, mental health, and other components be woven together to drive health security for all people? Malconfigurations of care are, for many Americans, one of the most concrete and visible manifestations of health care anarchy. Reconfiguring care is one of the most powerful ways to demonstrate to Americans that reform is working for them.

Chapter 11 focuses on primary care. Primary care is essential. It has elicited many words but virtually no effective action—so far. Without primary care, patients often fail to use care well. Patients who lack a solid relation with a trusted primary care doctor are more likely to delay care-seeking. The short—and worsening—supply of primary care doctors is owing to low incomes, heavy paperwork burdens, and lack of time to build trusting relations with patients—or assure coordination and continuity of comprehensive care. Shortage of primary care means fragmented care and higher cost. Health care increasingly resembles a solar system—minus a sun to hold the planets in their orbits.

Why is that? Partly because no entity, public or private, has any accountability for identifying how many primary caregivers America needs, or for paying enough of them well enough to enter and remain in primary care. Free tuition, loan forgiveness, and similar paltry policies have failed.

What changes are needed? How to win political support for financing those reforms? Boosting primary care doctors' incomes to $400,000 yearly plus 30 percent for fringe benefits would be a good start. So would cutting panel size to about 1,000 patients. This would cost a total of about $175 billion yearly, or about 3 percent of health spending. Cutting pointless paperwork would be a useful complement.

Good primary care is essential to ensuring access to care, high-quality and appropriate care, and health care cost control. Persisting inertia on training and paying for primary care will paralyze reform. Because it takes so long to train doctors, continued delays in training and paying many more primary caregivers will impede reforms in access, quality, and cost. This means that primary care reform is the critical path forward. Because it will take the longest time to address, it must command large and prompt investments as soon as possible.

Chapter 12 examines the configuration of hospital care, how it can be improved—and financed. Rural hospital closings are one manifestation of anarchy in hospital configuration. Another is the high rate of closings of urban hospitals, especially mid-size non-teaching hospitals, and especially in Black neighborhoods. When hospitals close, doctors who'd relied on them often choose to retire or relocate their practices.

Hospital care has become increasingly expensive and concentrated in fewer, larger institutions.

Only one state even has a list of the hospitals and ERs needed to protect the people's health. It is the only state with the legal obligation—and analytic skills—to pay each needed hospital enough money to finance efficient delivery of needed care.

Chapter 13 sketches the deepening problems in long-term care. Causes include the high cost of LTC, which stems from the need for many hours of help daily for weeks, months, or years. It examines the aims of LTC. What do disabled people want? And how can LTC help advance safe, comfortable, and dignified care that accords with those preferences? It suggests a few practical ways to bridge the widening gap between growing need and constrained resources.

Chapter 14 seeks feasible ways to improve mental health care delivery and financing.

Chapter 15 asserts that winning affordable meds for all Americans is the easiest problem to fix inside the easiest problem of health care itself. How can we attain the two good things we need?—strong incentives to innovate coupled with low prices for meds that actually are safe and effective. A first key step will be to integrate FDA decisions about safety and efficacy of new meds with decisions to pay for those meds using a portion of a yearly meds budget. A second will be to share costs of research fairly with other rich nations. A third will be to reward meaningful pharmaceutical innovation very generously while keeping the costs of the first pill out of the price of subsequent pills.

Chapter 16 examines sources of low and unequal quality in health care and identifies reforms that shift attention and resources to raising the floor—the worst care we allow many people to suffer—while giving somewhat less attention to the ceiling—the best care available to only a minority of people. It focuses on the strong tendency to deliver lower-quality care to the very citizens who are most vulnerable. And it also addresses the causes of more random problems of inappropriate or low-quality care.

And chapter 17 brings together the book's main assessments, evidence, and recommendations. It then describes the main alternatives to careful and comprehensive reform, and discusses the dangers they would pose to Americans and America.

This book makes no claim to working outside the box.

U.S. health care today is box-less.

The anarchy that pervades U.S. health care has steadily washed away all traces of a coherent, affordable, equitable, respectable, and accountable box. The job that faces Americans is not to think outside the box—but rather to find ways to construct a solid, functional, and durable box.

And to tell the story of how it could be built. Financially, politically, medically.

Too many of us struggle to make incremental improvements against great odds. Improvements that are, it seems, vulnerable to easy reversal when political winds shift. That's because most past reforms rest on shallow foundations, vulnerable to flooding and rot. They were not crafted to be durably affordable, widely embraced politically, or acceptable to enough patients or caregivers.

That $5.3 trillion is being spent on U.S. health care in 2025 means that crafting durably affordable, equitable, and effective health care should be the easiest problem to solve in our nation.

A good thing—since a crisis in financing, stemming from an event like a freeze in federal health dollars—will require deep and coordinated reform.

But it's hard to design and sew parachutes for passengers whose plane's motor has just stopped.

So we should prepare.

Words and acronyms

Words

The words “consumer” and “provider” are often used in health care. That is bad.

Why? Because they are mechanical and not very human. And because they falsely suggest that a functioning competitive free market exists in health care—one where equally informed and powerful buyers and sellers seek the best deal for themselves. Thomas Vaughan of Delaware’s Bayhealth writes that some:

> physicians find [provider] a very negative and derogatory term to address them. It is felt to have come from insurance companies and others who are trying to make medicine transactional, as opposed to a relationship between patients and physicians.[1]

Dinerstein writes that:

> calling the patient “consumer”. . . reduces physicians to knowledgeable salespeople, thoughtfully helping you select the proper diagnosis and treatment. More importantly, being a consumer creates an unrecognized responsibility, to have enough knowledge to clearly articulate their problems and needs. This is a difficult task for physicians with years of dedicated training; it is an impossible burden for a patient, especially when fear or anxiety accompany their concerns.
>
> Being a patient is the ability to trust that your vulnerability will be acknowledged and respected. Being a physician is to recognize you are being entrusted with need, not desire, and to act as a servant to those needs. [2]

Since both words suggest a functioning free market, it is ironic that they entered health talk from federal laws financing health planning. Building on the War on Poverty’s themes of citizen participation and of maximum feasible participation of the poor in programs affecting them, the federal health planning laws of 1966 and 1974-5 demanded majorities of “consumers” on their governing boards.[3] [4] Consumers were those who did not give care to address patients’ health problems. Similarly, Medicare labeled as providers those caregivers eligible to be paid by the program.[5]

These two words should and will be avoided whenever possible. Instead, words like “patient,” “person,” “human,” or “citizen” will be used in place of “consumer.” Each is intended in its most universal sense, not in a narrow or legal sense.

Still, as Fein reminds us, the Newspeak was not adopted randomly:

> [P]hysician-administrators speak the language that they speak because they reflect the world in which they live and the system in which they function. If society wants them to use different words, it must create conditions that encourage them to do so. This means replacing existing payment systems and funding patterns….[6]

Generally, the word “caregiver” will be used in place of “provider.” Caregivers include professionals like doctors, nurses, dentists and also organizations like hospitals, ambulatory surgery centers, nursing homes, and hospices.

The words “market competition” make it hard to understand health care problems, their causes, or effective remedies. (Similarly, it is not helpful to talk about the “players” in the “health care.”)

One director of a large health policy agency used the word “market” 52 times in a 45-minute talk in January of 2023. He said things like “the market rewards X” or “punishes Y.” Life would be happier—and health care would be much more affordable and simple—if we could count on the lure of profit to spur cost-cutting innovations, overthrow health care monopolies, slash prices, and excise clinical and administrative waste. But we can’t—for the many reasons catalogued in chapter 4. So we should avoid worshipping—or even invoking—an imaginary golden calf.

Acronyms

Health care has far too many. And they breed rapidly. New ones are manufactured by would-be reformers much faster than old ones become extinct. Some once-good acronyms have been expropriated: HSA refers today to Health Savings Accounts, no longer to regional planning bodies called Health Systems Agencies.

Fewer acronyms would signal better, simpler, cheaper, and more trustworthy health care. It is not comforting that the French make even more profligate use of acronyms.[7] This book will try to use the 150 or so acronyms that follow as seldom as possible.—

ACA	Affordable Care Act of 2010 (Obamacare) - Medicaid expansions, subsidized individual insurance, children <26 covered under parents’ private insurance
ACO	Accountable care organization
ADI	Area Deprivation Index – a measure of social predictors of higher health costs – a factor in calculating HEBA, the Health Equity Benchmark Adjustment
AHIP	America’s Health Insurance Plans – lobbying arm of insurance companies
REACH	A type of ACO – Realizing Equity, Access, and Community Health
AHA	American Hospital Association
AHEAD	States Advancing All-payer Health Equity Approaches and Development – 2023 federal demonstration program to propagate Maryland-style all-payer and fixed budget methods of paying hospitals
AHRQ	Agency for Health Care Research and Quality (formerly NCHSR)
AI	Affordable idealism **or** assured integrity **or** accountable institutions—**not** artificial intelligence
ALF	Assisted living facilities – supportive housing for disabled elders who do not want or need nursing home care; usually financed privately (since Medicaid rarely pays for ALF care) so are affordable only for more affluent people
AMA	American Medical Association
AMC	Academic medical center
APC	Medicare’s ambulatory payment classification – similar to inpatient DRGs, but for outpatient care at hospitals
BC	Blue Cross - original private (non-profit) hospital insurance, started by regional or state hospital associations in the 1930s
BS	Blue Shield - original doctor insurance, started by state medical societies in 1930s, usually merged with state or regional BC plans now

CAH	Critical access hospital - one of some 1,300 fairly isolated rural hospitals that are cost-reimbursed by Medicare, not paid by DRGs
CBO	Congressional Budget Office
CHIP	Children's Health Insurance Program – federally-financed and state-run program created in 1997 to cover children in families whose incomes are too high to qualify for Medicaid
CHNA	Community health needs assessment—the ACA obliged hospitals to conduct these every three years
CNA	Certified nursing assistant – they provide most care in nursing homes
CMI	Case mix index is average case weight of Medicare DRGs, a measure of both severity of illness and expected cost of care
CMMI	Center for Medicare and Medicaid Innovation
CMS	Center for Medicare and Medicaid Services (named HCFA until 2001)
COPA	Certificate of Public Advantage – states can award these to trump anti-trust laws and allow a monopoly-creating merger when believed to be desirable
CPI	Consumer price index – a measure of inflation – its medical component is almost meaningless since it measures charges, which are rarely paid – PPI is much better
CPR	Customary, prevailing, and reasonable fees paid doctors - Medicare's name for UCR (usual, customary, and reasonable) - used before 1992 switch to RBRVS
CPT	Current procedural terminology - prepared by AMA - classifications of physicians' services - usually for billing; sometimes to compare quality
CQI	Continuous quality improvement (also called TQM, total quality management) – seeks to improve systems of care, not blame individuals
CR	Cost-reimbursement - Blue Cross plans' main original method of paying hospitals, also adopted by Medicare from 1966 to 1983
CY	Calendar year
DHHS	U.S. Department of Health and Human Services
DOH	Drivers of health – a CMS approach to SDOH or SDLs that considers solely food, housing, transportation, utility bills, and personal security
DRG	Diagnosis-related group, one of 740 or so categories of discharges from hospitals that are Medicare's units of payment for inpatient care using Medicare's IPPS
DSH	Disproportionate share hospital - recipients of special, extra Medicare and Medicaid payments for serving higher shares of Medicaid, Medicare, and uninsured patients
DSO	Dental service organization – groups of dentists, often investor-backed or – controlled, that negotiate with dental insurance companies
DT	Diagnosis and Treatment – systemic evidence-based analysis of problems, their causes, and remedies that actually address causes
ED	Emergency department – fancy name for emergency room
EHI	Employer-sponsored health insurance – also EPI or ESI
EHR	Electronic health record—intended to include broader information than EMR
EMR	Electronic medical record
EMTALA	1986 Emergency Medical Treatment and Active Labor Act - requires hospitals with ER to treat and stabilize emergency patients - can still send bill
ER	Emergency room
ERISA	Employee Income Retirement Security Act of 1974 - 1 provision prohibited states from regulating health insurance plans in which the employer (not the insurance company) bore risk
EPI	Employer-provided insurance—also ESI or EHI

ESI	Employer-sponsored insurance = EPI or EHI
FAT	Proposed Food Assistance Tax on spending on meals away from home in excess of $15 per person; revenue used to expand SNAP
FFS	Fee-for-service method of paying doctors, dentists, or other clinicians – actual fees can be set by lots of different methods
FFT	Fee-for-time – simpler method of paying doctors, especially primary care physicians (or primaries) – by hours worked
FFY	Federal fiscal year – starts 1 October – FFY 2025 contains 1 January 2025
FMAP	Federal matching assistance percentage - share of a state's Medicaid costs paid by federal government—higher for low-income states and during economic crises
FPL	Federal poverty level – set at $30,000 for a family of 4 in 2024 – but the typical rich democracy sets its poverty level higher, at one-half median income [8] – that one-half would be about $49,250 in the U.S. in 2023,[9] or about 60 percent above "FPL"
FSA	Flexible savings account – a rigid way to set aside earned income to pay OOPs with pre-tax dollars – offers much greater benefits to those in high federal tax brackets
FTC	Federal Trade Commission - one of the two main federal anti-trust organizations
FTE	Full-time equivalent (workers) - Usually, all full-time workers + one-half of part-timers = FTEs
FYE	Fiscal year ending (on a certain day, such as 30 September for federal fiscal years)
GAO	Government Accountability Office - Congress's investigative arm –called the General Accounting Office until 2004
GBR	Global budget revenue – Maryland's name for hospitals' fixed yearly budgets—also called hard static budgets
GIM	General internal medicine
GME	Graduate medical education – usually, of doctors
GDP	Gross domestic product, value of all goods and services in a nation
GSP	Gross state product – state equivalent of GDP
HCA	Health care accountability – state that is opposite of anarchy – relevant parties are clinically or financially accountable
HCA	Hospital Corporation of America – the first and largest for-profit hospital chain
HCC	Hierarchical condition categories – used to risk-adjust capitation payments to Medicare Advantage plans – recognized as wide open to corrupt generation of massive undeserved revenues by making patients seem costlier than they really are
HCFA	Health Care Financing Administration (renamed CMS in 2001 = federal Medicare + Medicaid agency)
HCFA	Health Care for All = name for Massachusetts and national reform groups; earlier, used by Herb Dennenberg, late Pennsylvania insurance commissioner[10]
HDHP	High-deductible health plan – which people must choose if they wish to contribute money to an HSA (health savings account)
HEBA	Health Equity Benchmark Adjustment (when capitating REACH ACOs serving people whose care is predictably more costly for either medical or social reasons)
HHS	U.S. Department of Health and Human Services (also DHHS)
HMO	Health maintenance organization, responsible for serving finite population with fixed dollars – one type is PPGP (pre-paid group practice with salaried docs – Kaiser is prominent example); other type is IPA (independent practice or professional association with FFS-paid docs)
HPSA	Health professionals shortage area (federal standard is <1 PC per 3,500 people)
HRRP	Medicare's Hospital Readmissions Reduction Program

HRSA	U.S. Health Resources and Services Administration – part of DHHS
HRSN	Health-related social needs = social determinants of health = social determinants of life
HSA	Health systems agency - federally-financed regional health planning agencies of 1970s
HSA	Health savings account - place to invest before-tax $s - which could be used to pay OOPs, coupled with high-OOP high-deductible health plan – particularly benefits higher-income Americans
HSCRC	Health Services Cost Review Commission – Maryland hospital payment regulatory authority, learning on the job since 1971
HTA	Health technology assessment
HUD	U.S. Department of Housing and Urban Development
ICD	International classification of diseases, published by WHO
IHS	Indian Health Service –federal agency to provide health services to first Americans – quality problems arise – owing partly to under-financing, caregiver shortages
IPA	Independent practice (or professional) association - FFS-type HMO with independent doctors paid FFS and static budget
IPPS	Medicare's prospective payment system for hospital inpatient care – payment by DRGs
IRA	Inflation Reduction Act of 2022 – empowered Medicare to negotiate prices of 10 meds in first year, and more subsequently; boosted federal subsidies for insurance purchase through ACA marketplace plans, thereby lowering families' premiums
IRMAA	Medicare Part B and D Income Related Monthly Adjustment Amount – can be viewed either as a take-back of federal subsidies to Part B and D premiums for higher-income recipients, or as a steep tax on higher-income recipients
LIS	Federal Low-income supplement to help citizens afford Medicare Part D drug plan premiums
LTC	Long-term care - needed for months or years, not short-term rehab or recuperation
MA	Medicare Advantage - capitated part of Medicare featuring competing managed care plans – designed to save money but failed to do so owing to insurer gaming of capitation payments by making enrollees look sicker than they actually are
MACPAC	Medicaid and CHIP Payment Access Commission – advises Congress on Medicaid and CHIP access, payment rates, and methods of payment
MAT	Medically assisted treatment (for substance abuse)
MACRA	Medicare Access and CHIP Reauthorization Act of 2015 – codified notional incentive payments to doctors – refer to MIPS
MCO	Managed care organization – umbrella term for HMOs, PPOs, ACOs, and other O-methods of capitating payments to care for groups of people
MedPAC	Medicare Payment Advisory Commission – independent group advising Congress on Medicare payment rates and methods
MEI	Medicare economic index – aims to track changes in physicians' cost of practice
MIPS	Merit-based Incentive Payment System - Medicare pays doctors more money if they use EHR, adhere to quality measures, and contain cost – imagined to mean "pay for value"
MLR	Medical loss ratio – insurance business term for percentage of insurance premiums going to pay for actual health care; also called "care share;" the ACA set a minimum care share of 85% of premiums for groups of more than 100 employees
MPFS	Medicare physician fee schedule (using RBRVS – resource-based relative value scale)

MPT	Medical Properties Trust
MSSP	Medicare shared savings program (using ACOs)
NCHSR	National Center for Health Services Research – Congress cut funding cut and almost eliminated it after its analyses angered small group of doctors (see also OTA) – now reconstituted as AHRQ
NHE	National health expenditures – all money spent on U.S. health care yearly, some $4.7 trillion in 2023
NHS	U.K.'s National Health Service
NP	Nurse practitioner
NSA	No Surprises Act of 2020 – made progress addressing surprise bills
OACT	Office of the Actuary of CMS – which measures federal and state health care cost
OASI	Old Age and Survivors Insurance – Social Security
OASDI	Old Age, Survivors, and Disability Insurance – Disability was added in 1972
OECD	Organization for Economic Cooperation and Development – the club of (mainly) rich democracies (38 in 2023)
OIG	Office of Inspector General - investigates fraud, other bad behavior; each federal department has one
OON	Out-of-network = care obtained outside a network established by an insurance company's PPO (preferred provider organization) or other narrow network
OOP	Out-of-pocket payments = deductible, co-insurance, or co-payment, up to yearly OOP maximum
OTA	Congressional Office of Technology Assessment – defunded and closed owing to pressure from a small group of doctors who felt financially threatened by its analyses
P4P	Pay for performance—ostensibly different from paying by the unit of care
P4V	Pay for value (not volume) – used interchangeably with P4P
PA	Physician assistant
PAAM	Profit, administration, advertising, and marketing
Part A	Medicare social insurance for inpatient hospital care and a little SNF (skilled nursing facility) care, financed by 2.9 percent payroll tax on all earned income
Part B	Medicare insurance for doctor care, hospital outpatient care, and certain drugs, one-quarter financed by premiums and three-quarters by federal general revenues
Part C	Medicare Advantage plans = private, capitated plans that enrolled one-half of Medicare patients by the fall of 2023
Part D	Medicare's main prescription drug benefit, financed one-quarter by premiums and three-quarters by federal general revenues; delivered through private insurers
PBM	Pharmacy benefits manager – hoped by some to squeeze drug makers to obtain lower prices for employers, workers – not found in other nations – have sometimes betrayed fiduciary duty to clients
PBP	Population-based payment (such as capitation)
PBS	Policy by spasm – whimsical adoption of policies—often absent evidence that they work—that don't address causes of problems—often in reaction to failed policies
PC	Primary caregiver (pediatrician, family practitioner, general internal medicine internist, sometimes OB or NP or PA)
P-D	Patient-days (average daily census * number of days in year or other period)
PGY	Post-graduate year(s) after medical school (PGY1 = former rotating internship)

PHCE	Personal health care expenditures, the 85% of NHE that pays for care for individuals; it includes *caregivers'* administrative costs (PHCE excludes the 15 percent of NHE going to research, *payers'* administrative costs, construction, equipment, and insurance company profits)
PHI	Private health insurance – an umbrella term for employer-sponsored insurance, individually-bought private insurance, and sometimes the ACA's subsidized individual insurance bought via ACA marketplaces
MM	Member-months – a handy denominator that combines full- and part-year member of a managed care or other organization – distinct from M&Ms
PMPM	Per member per month – often used to denote monthly capitation rates that a payer gives to a managed care operation, which is then responsible for delivering needed care to those members; could also refer to rates of use of x type of care PMPM
PMPU	Per member per utilizer – rates of use of y type of care by those who actually use it during a certain period
PPGP	Pre-paid group practice - Kaiser-type capitated HMO responsible for total static budget, with salaries for doctors and budgets for hospitals owned by the PPGP
PPI	Producer price index - hospital and doctor indices used to calculate inflation-adjusted constant dollars; the PPI measures prices actually paid, unlike the medical care component of the consumer price index (CPI), which measures charges and is meaningless because hardly anyone pays caregivers' charges
PPO	Preferred provider organization - with lower OOPs if patient uses preferred doctors/hospitals – these narrow networks do little to contain cost but can impair access to care
PPS	Medicare's prospective payment system (also called IPPS for inpatient hospital care) adopted in 1983
RBRVS	Resource-based relative value scale - how Medicare pays doctors' fees - adopted in 1992 – intended partly to narrow gap between incomes of doctors who think and those who perform procedures - imagined by its developers to measure actual cost of care and price that would be paid in a competitive free market – it's another formula-based payment
RCM	Revenue cycle management - extracting payments from patients or from third party payers
REACH	Realizing Equity, Access, and Community Health – an ACO option starting in 2023
RU	Revenue per unit of care (actual sum paid for care)
RUC	AMA's relative value update committee, dominated by specialists, that recommends price adjustments – those are subject to RBRVS's zero-sum requirement
RVU	Relative value unit = a measure of time, skill, and effort required to deliver a particular professional treatment (usually by a physician)
SAMHSA	Substance Abuse and Mental Health Services Administration, part of U.S. DHHS
SDL	Social determinants of life
SDOH	Social drivers (or determinants) of health
SGR	Medicare's sustainable growth rate, a method formerly employed to limit rise in total Medicare payments to doctors in proportion to economic growth
SNAP	Federal Supplemental Nutrition Assistance Program, formerly called "food stamps"
SNF	Skilled nursing facilities - nursing homes that Medicare and Medicaid will pay for
SNP	Special needs plan in Medicare Advantage, mainly for dual eligibles (D-SNP)
SSDI	Social Security Disability Income – recipients become eligible for Medicare after 2 years

SSI	Supplementary Security Income
SUD	Substance use disorder – abuse of or addiction to alcohol, nicotine, or other chemicals
USC	Usual source of (primary) care – an individual caregiver or an organization
TM	Traditional Medicare – not Medicare Advantage
USC	Usual source of (primary) care
VHA	Veterans' Health Administration - delivers acute, ambulatory, mental health, and LTC to U.S. veterans
WHO	World Health Organization

MACPAC has an extensive list of acronyms here, https://www.macpac.gov/reference-materials/reference-guide-to-federal-medicaid-statute-and-regulations/macpac-acronyms-list/.

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